Michigan Department of Community Health

DRAFT HIPAA 5010A1 EDI Companion Guide for ANSI ASC X12N 837I Institutional Encounter

Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs)

Version Date March 7 2011

Effective January 1, 2012

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

Table of Contents

Introduction

This document is the property of the Michigan Department of Community Health (MDCH). The information contained in this document is for the use of Trading Partners engaging in electronic data interchange (EDI) health care transactions with the State of Michigan's Community Health Automated Medicaid Payment System (CHAMPS).

This document is intended as a companion to the 005010X223 • 837I Health Care Claim: Institutional Technical Report 3 (TR3) dated May 2006. This document also includes updates appearing in:

- Errata 005010X223A1 • 837I Health Care Claim: Institutional dated October 2007
- Errata 005010X223E1 • 837I Health Care Claim: Institutional dated January 2009
- Errata 005010X223A2 • 837I Health Care Claim: Institutional dated June 2010

The TR3 documents replace the 4010A1 Implementation Guide and related Addenda. The 5010A1 TR3 and related Errata documents can be downloaded from the Washington Publishing Company web site at http://www.wpc-edi.com/content/view/817/1.

This document is expected to be used in conjunction with the TR3 and related Errata for the 837I transaction set. The content of this document follows the guidelines authorized in the version modifications to the Health Insurance Portability and Accountability Act (HIPAA) Final Rule transaction standards published in the Federal Register January 16, 2009.

This document provides MDCH-specific instructions regarding certain elements within the TR3 but does not change, supersede, or add to the definitions, data conditions, or use of data elements or segments in the standard. This document provides MDCH rules regarding:

- Identifiers to use when a national standard has not been adopted
- Parameters in the TR3 and related Errata that provide options

In order to successfully download HIPAA transactions from the CHAMPS system it is necessary to comply with the information contained in the MDCH Electronic Submission Manual Dated February 2009. Note that revision of the MDCH Electronic Submission Manual is expected during calendar year 2011. The most current version of this manual can be downloaded from the MDCH web site at the following location: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42545_42638---,00.html.

Transaction Description

This transaction set is used to exchange health care claim and/or encounter information, or both, from providers of health care services to payers including managed care organizations. This transaction can be submitted either directly or via intermediary billing services and/or claims clearinghouses.

Upload/Submission Notes for ANSI ASC X12 837I Institutional Encounter

This Companion Guide is intended for use in the electronic submission for health care encounter claims. Please refer to the MDCH website for Companion Guide supporting the submission of health care fee-for-service claims. Claims and encounters cannot be sent on the same 837 Transaction file.

Please refer to the MDCH Electronic Submission Manual for information regarding:

- Interaction with the MDCH's Data Exchange Gateway (DEG)
- Modes of submission (FTP, SSL FTP, or HTTPS)
- Interchange Acknowledgement (TA1) transaction
- Interchange Acknowledgement (999) transaction

This document uses several text conventions to distinguish MDCH data elements from the TR3 data elements. The following table lists the text conventions used in this document.

Convention used	Explanation
< >	Text included within < > is the "Implementation Name" field from the TR3 document.
" "	Text with " " around a value represents HIPAA TR3 values.
( )	The HIPAA TR3 description of the value in quotes, described above, is provided parenthetically.

ANSI ASC X12 837I Institutional Encounter Companion Guide Rules

837I - Interchange Control Header

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment - Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Authorization Information Present (No Meaningful Information in I02))
	ISA	ISA02	Authorization Information	10 Spaces
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present (No Meaningful Information in I04))
	ISA	ISA04	Security Information	10 Spaces
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	Trading Partner ID Use the DEG ID left justified, followed by spaces.
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	ISA	ISA08	Interchange Receiver ID	"ENCOUNTER" left justified followed by spaces.
			Functional Group Header	
	GS		**Segment - Functional Group Header**	
	GS	GS02	Application Sender's Code	Trading Partner ID Use the DEG ID. This value should always match ISA06 <Interchange Sender ID>
	GS	GS03	Application Receiver's Code	"ENCOUNTER" for MDCH

837I - Transaction Set

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Transaction Set Header	
	ST		**Segment - Transaction Set Header**	**MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA mandated implementation guide. Submissions greater than 5,000 CLM segments in a single transaction will be rejected.**
	BHT		**Segment - Beginning of Hierarchical Transaction**	
	BHT	BHT03	Reference Identification	<Originator Application Transaction Identifier> MDCH requires this number to always be unique. This number may not be used again even if the prior batch is rejected.
	BHT	BHT06	Transaction Type Code	<Claim Identifier> "'RP" (Reporting) for Encounters.
1000A			**Loop - Submitter Name**	
1000A	**NM1**		**Segment - Submitter Name**	
1000A	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
1000A	NM1	NM109	Identification Code	<Submitter Identifier> Use the DEG ID This value should always match ISA06 <Interchange Sender ID> and GS02 <Application Sender's Code>
1000B			**Loop - Receiver Name**	
1000B	**NM1**		**Segment - Receiver Name**	
1000B	NM1	NM103	Name Last or Organization Name	<Receiver Name> "Michigan Department of Community Health" or "MDCH"
1000B	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement)
1000B	NM1	NM109	Identification Code	<Receiver Primary Identifier> "D00111" for MDCH.
2000A			**Loop - Billing Provider Hierarchical Level**	
2000A	**PRV**		**Segment - Billing Provider Specialty Information**	
2000A	PRV	PRV01	Provider Code	"BI" (Billing)
2000A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2000A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDCH requires taxonomy code to always be submitted to identify the provider specialty.
2000B			**Loop - Subscriber Hierarchical Level**	
2000B	**SBR**		**Segment - Subscriber Information**	
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	"P" if MDCH is the only payer (patient has no Medicare or other insurance).
2000B	SBR	SBR09	Claim Filing Indicator Code	"MC" (Medicaid) "TV" (Title V) for CSHCS "OF" (Other Federal) for MIChild and ABW "11" (Other Non-Federal) for State Medical Plan or for persons not enrolled in Medicaid. If recipient qualifies for more than one program, or other MDCH program not listed, use "MC" (Medicaid).
2010BA			**Loop - Subscriber Name**	
2010BA	**NM1**		**Segment - Subscriber Name**	
2010BA	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number).

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2010BA	NM1	NM109	Identification Code	<Subscriber Primary Identifier> Medicaid and ABW plans use the 10-digit beneficiary ID number assigned by MDCH. MIChild enrollees use the Client Identification Number (CIN) assigned by the enrollment broker. Use the 11-digit Consumer Unique ID (CONID) assigned to the patient by Mental Health Prepaid Inpatient Health Plans (PIHP) or Community Mental Health Service Program (CMH) **only** when the person is not enrolled in Medicaid, ABW or MIChild.
2010BB			**Loop - Payer Name**	
2010BB	**NM1**		**Segment - Payer Name**	
2010BB	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2010BB	NM1	NM109	Identification Code	<Payer Identifier> "D00111" for MDCH.
2000C			**Loop - Patient Hierarchical Level**	**MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect health plans to submit any Loop - 2000C Patient Hierarchical Levels in a transaction set.** **Transaction sets that contain Loop - 2000C Patient Hierarchical Level information will be rejected.**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2300			**Loop - Claim information**	**Note that the HIPAA mandated implementation guide allows a maximum of 100 repetitions of the Loop - 2300 Claim Information within each Loop - 2000B Subscriber Hierarchical Level. Transaction sets that do not associate Loop - 2300 Claim Information with Loop - 2000B will be rejected.**
2300	**CLM**		**Segment - Claim information**	
2300	CLM	CLM05-1	Facility Code Value	<Facility Type Code> First 2 digits of Type of Bill.
2300	CLM	CLM05-3	Claim Frequency Type Code	<Claim Frequency Code> "1" on original encounter submissions "7" for encounter replacement "8" for encounter void/cancel For both "7" and "8", include the original Encounter Reference Number (ERN), as indicated in Loop - 2330B REF02 (Other Payer Claim Control Number).
2300	**CN1**		**Segment - Contract Information**	
2300	CN1	CN101	Contract Type Code	MDCH requires this data element on encounters where the health plan contract arrangement with the provider is other than fee-for-service.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2310A			**Loop - Attending Provider Name**	
2310A	**PRV**		**Segment - Attending Provider Specialty Information**	
2310A	PRV	PRV01	Provider Code	"AT" (Attending)
2310A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2310A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDCH requires taxonomy code to identify the provider specialty.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2320			**Loop - Other Subscriber Information**	**MDCH does require the health plan to report Loop - 2320 Other Subscriber Information. The health plan (Mental Health Prepaid Inpatient Health Plans (PIHP) as well as any Community Mental Health Service Program (CMH) affiliate responsible for the services being reported in the encounter transaction) will be identified as a payer in Loop - 2330B Other Payer Name. The information reported in this iteration of Loop - 2320 is specific to the subscriber's coverage through the health plan. Other payers such as Medicare or other commercial carriers are reported in additional iterations of this loop. In the event of additional payers, Loop - 2320 Other Subscriber Information would be repeated and would be specific to its respective Loop - 2330B Other Payer Name.** Valid combinations are: **Health Prepaid Inpatient Health Plans (PIHP)** - *Required (once)* *and/or* **Health Service Program (CMH) -** *If applicable (once)* *and/or* **Other Payers (Medicare or other commercial carriers) -** *If applicable*
2320	**SBR**		**Segment - Other Subscriber Information**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	If the patient has other insurance, report primary payer coverage with code “P” and any other insurance with codes “S” or “T”, as appropriate. If the patient has no other insurance, report the health plan coverage with "P".
2320	SBR	SBR03	Reference Identification	<Insured Group or Policy Number> Subscriber’s group number (assigned by the health plan or the other payer), not the number that uniquely identifies the subscriber.
2320	SBR	SBR09	Claim Filing Indicator Code	“MC” (Medicaid) “TV” (Title V) for CSHCS “OF” (Other Federal) for MIChild and ABW “11” (Other Non-Federal) for State Medical Plan or for persons not enrolled in Medicaid. If recipient qualifies for more than one program, or other MDCH program not listed, use “MC” (Medicaid).
2320	**CAS**		**Segment - Claim Level Adjustments**	**MDCH requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**
2330A			**Loop - Other Subscriber Name**	**Loop - 2330A Other Subscriber Name, segment NM1 is required for all encounters. The subscriber information reported is specific/related to the health plan and/or any other additional other payer information submitted on Loop - 2330B Other Payer Name.**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2330A	**NM1**		**Segment - Other Subscriber Name**	
2330A	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number).
2330A	NM1	NM109	Identification Code	<Other Insured Identifier> This element is intended to report the unique member number assigned by the health plan or other payer. Community Mental Health Prepaid Inpatient Health Plans (PIHP) and Community Mental Health Service Program (CMH) use the 11-digit Consumer Unique ID (CON ID) assigned by the enrollment broker.
2330B			**Loop - Other Payer Name**	**Loop - 2330B Other Payer Name, segment NM1 is required for all encounters. It is within this loop that the health plans (Mental Health Prepaid Inpatient Health Plans (PIHP) as well as any Community Mental Health Service Program (CMH) affiliate responsible for the services being reported in the encounter transaction) is required to report themselves as an Other Payer.** **In the event that there are other payers identified as having financial responsibility for the services being reported, the health plan would report them in subsequent iterations of Loop - 2330B.**
2330B	**NM1**		**Segment - Other Payer Name**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2330B	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification).
2330B	NM1	NM109	Identification Code	<Other Payer Primary Identifier> For health plans use the CHAMPS provider ID assigned by MDCH. For Other payers use the payer ID submitted on the claim.
2330B	**REF**		**Segment - Other Payer Claim Control Number**	
2330B	REF	REF01	Reference Identification Qualifier	"'F8" (Original Reference Number)
2330B	REF	REF02	Reference Identification	<Payer Claim Control Number> For encounters, MDCH requires a unique Encounter Reference Number (ERN) to always be submitted. For the health plan, enter the plan assigned unique identifier Encounter Reference Number (ERN) for the encounter. Include the Encounter Reference Number (ERN) of the previously adjudicated encounter when CLM05-3 <Claim Frequency Code> indicates this encounter is a replacement or void.
2400			**Loop - Service Line Number**	**Note that the HIPAA mandated implementation guide allows a maximum of 999 repetitions of Loop - 2400 Service Line Number within each Loop - 2300 Claim Information.**
2400	**SV2**		**Segment - Institutional Service Line**	**MDCH requires Health Plans to always submit combination of procedure codes and "HK" modifier on the first service line to identify the encounter as Habilitation Support Waiver (HSW) encounter.**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2400	SV2	SV203	Monetary Amount	<Line Item Charge Amount> MDCH requires the provider's usual and customary charge or billed amount. Zero (0) is a valid amount if: 1) The health plan has a subcapitated contract arrangement with the provider as designated in Loop - 2300 Claim Information, Segment CN1, CN101 (Contract Type Code) or Loop - 2400 Service Line Number, Segment CN1, CN101 (Contract Type Code) and the contract permits zero as a charged amount, or 2) The service(s) is/are recognized by MDCH as having no associated charge(s), for example, vaccines.
2430			**Loop - Line Adjudication Information**	**MDCH requires this loop for each payer identified in Loop - 2320 Other Subscriber Information, except when that payer has adjudicated this claim at the claim level only.**
2430	**SVD**		**Segment - Line Adjudication Information**	
2430	SVD	SVD02	Monetary Amount	<Service Line Paid Amount> MDCH requires the amount paid to the provider. Zero "0" may be reported if: 1) the service was not covered by the health plan, or 2) the service was covered under a subcapitated contract arrangement.
2430	**CAS**		**Segment - Line Adjustment**	**MDCH requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**

Revision Log

Version Date	Effective Date	Revision Description
March 7, 2011 (Draft)	January 1, 2012	This document replaces *Companion Guide For the HIPAA 837 Institutional Encounter Addenda Version 4010A1 Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs)* dated June 12, 2009.